STATEMENT	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1	. 12.211		
			I (X2) MULT	IPLE CONSTRUCTION /	(X3) DATE S	. 0938-0391
		IDENTIFICATION NUMBER:	A. BUILDIN		COMPL	ETED
		445491	B. WING_		03/0	9/2011
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE		
MCKENE	REE VILLAGE INC		1 3	347 LEBANON ROAD		
				IERMITAGE, TN 37076	OTION .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 176 \$S=D	483.10(n) RESIDENT DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), had practice is safe.  This REQUIREMENT by: Based on medical rand interview the faresident (#17) was administration of a residents reviewed.  The findings included Resident #17 was a January 31, 2011, anxiety State, Joint Depressive Disorder Medical record reviewealed, " Albuter every morning"  Observation of resident mask place and mouth; the neb	Introduction of Physician's red daround the resident's room at 10:35 a.m., revealed a red around the room or in line if the room or in line if the resident's nose culizer machine in the on illity staff in the room or in line if the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the on interest as defined by staff in the room or in line in the room or in	F 176	This Plan of Correction is submitted required under State and Federal facility's submission of the Plan of Correction (PoC) does not constitued admission on the part of the facility findings cited are accurate, that the constitute a deficiency, or that the severity determination is correct.  F 176 Resident Self administer dideemed safe:  1. Resident # 17 no longer resider facility. 2. The interdisciplinary team has diassessments on other residents whe nebulizer treatments for safe practices and will be completed by 29th, regarding the facility's policy procedure on the safe practice of self-administration of nebulizer treatments for safe practice of self-administration of nebulizer treatments for safe practices of self-administration of nebulizer treatments for safe practice of self-administration of nebulizer treatments. The Director of Nursing or her will randomly monitor three (3) times for four (4) weeks residents who hassessed by the interdisciplinary the safely self-administer nebulizer treatments for self-administer nebulizer treatments. The Director of Nursing will report during the monthly Performance Improvement (QA) of includes the Medical Director, Administer Managers, Housekeeping Stationard Representative, Administer Repres	ed as law. The tute an sy that the se findings scope and trugs, if the completed sho receive tice of the se finding ing or her sy March se weekly lave been seam to seatments, findings  Committee ministrator, as Director, Supervisor, hissions	
	nurse's desk, on Ma confirmed the charg nebulizer mask; turn	ge Nurse # 3 at the north hall arch 7, 2011, at 11:35 a.m., be nurse had attached the ned the nebulizer machine to	IATURE	Representative, and representative other departments, as necessary.  Completion date	es Irom	April 7, 2011

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Administrator

Facility ID: TN1934

March 23, 2011

### DEPARTMENT OF HEALTH AND 11 UMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

V-1111	TO TOTT WILDION TO	G MEDICHID SELVICES	-			CIVID INC	. 0930-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE 5 COMPL	BURVEY
		445491	B. WIN	IG_		03/0	9/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
MCKENI	OREE VILLAGE INC				347 LEBANON ROAD ERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 176	Continued From pa	ge 1	F1	76	F226 Implementation of Abuse poli	су.	
F 226 SS=D	the on position, placed the Albuterol inside the plastic cylinder attached the nebulizer mask and left the room. Continued interview at this time confirmed the resident had not been assessed for self administration of medications prior to self administration.  483.13(c) DEVELOP/IMPLMENT		the on position, placed the Albuterol inside the plastic cylinder attached the nebulizer mask and eft the room. Continued interview at this time confirmed the resident had not been assessed for self administration of medications prior to self administration.  483.13(c) DEVELOP/IMPLMENT  F 22		The Director of Nursing and the I Director completed a thorough inverthe alleged verbal abuse reported the #13. This review was completed or 10th, and included record review as with individuals involved.     The facility staff followed its abus procedure and suspended the PTA.	stigation of by Resident in March ind interviews se policy & (Physical	
33-0	The facility must de policies and proced mistreatment, negle	velop and implement written		3	Therapy Assistant) who was allege been involved in the incident involved #13. This individual, who was not a employee, but a facility contractor, immediately suspended from work excluded from any contact with faci pending the outcome of the investig 3. The Director of Social Services 6	ing Resident an was and lity residents pation.	
	by: Based on medical rand interview, the fabuse policy after a for one resident (#1 investigation for injudent)	NT is not met as evidenced record review, policy review, acility failed to implement the in allegation of verbal abuse 3); and failed to complete an ury of unknown origin resident (#16) of twenty-six			designee have begun random residinterviews and will complete these is by March 31st. These interviews as preventative measure that the facilities a proactive effort to identify other unreported allegations of verbal about any exist. The Director of Social Seconduct inservice training for the facility's policy procedure regarding allegations of reporting requirements by March 25 staff members who are unable to at	ent nterviews re a ty is taking possible use, should ervices will cility staff in cy & abuse and oth. For tend due to	
	Resident #13 was admitted to the facility on February 11, 2011, with diagnoses of History of Falls, Acute Kidney Failure, and Asthma.  Medical record review of the Minimum Data Set dated February 18, 2011, revealed the resident was able to perform interview.  Interview with resident #13 on March 8, 2011, at 9:00 a.m., in the resident's room, revealed the resident complained a PTA (physical therapy assistant) had been verbally abusive.				leave; vacation, et cetera, training v provided upon their return to work.  4. The Director of Social Services of the findings of the random interview monthly Performance Improvement meeting. The Performance Improve Committee includes the Medical Dir Administrator, Director of Nursing, S Services Director, Nurse Managers Housekeeping Supervisor, Mainten-Representative, Admissions Coordi Medical Records Representative, a representatives from other departmeecessary.  Completion date	will report s during the (QA) ement (QA) ector, ocial ance nator, nd	March \$1, 2011

DEPARTMENT OF HEALTH AND JUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  MCKENDREE VILLAGE INC    CAG ID PREFIX   CACI INFORMATION   PREFIX   PROVIDER PROVIDER OF THE APPROPRIATE   PROVIDER OF THE APPROPRIATE   PROVIDER OF THE APPROPRIATE   PROVIDER PLAN OF CARD OF THE APPROPRIATE   PROVIDER PLAN OF THE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
STREET ADDRESS, CITY, GTATE, ZIP CODE 4371 TEBANON ROAD			445491	B. WING		03/09/2011
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 228  Continued From page 2  Interview with CNA#2 (certified nursing assistant) on March 8, 2011, at 2:10 p.m., in the hallway, confirmed had overheader DTA had made harsh remarks to the resident. Continued interview revealed CNA #2 had seen the resident crying immediately after the incident and had to comfort the resident. Further interview revealed the CNA had reported the allegation to the nurse at the time of the incident.  Review of the facility's policy Preventing Resident Abuse, revealed "(1) monitoring staff on all shifts to identify inappropriate behavior toward resident"  Interview with the Administrator and Social Services on March 8, 2011, at 2:45 p.m., in the Administrator's office, confirmed had no knowledge of any allegation and verified no verbal allegation had been investigated.  Resident # 11 was admitted to the facility July 25, 2006, with diagnoses including Senile Dementia, Alzheimer's Disease, Congestive Heart Failure, Hypertension, Osteoarfiritis, Joint Pain and Bone/Cartilage Disorder.  Medical record review of the Minimum Data Set dated November 10, 2010, revealed the resident had long and short term memory problems, severe cognitive impairment, was non-ambulatory, required extensive assistance with transfers.  April 7, Completion date					4347 LEBANON ROAD	
Interview with CNA#2 (certified nursing assistant) on March 8, 2011, at 2:10 p.m., in the hellway, confirmed had overheard PTA had made harsh remarks to the resident. Continued interview revealed CNA #2 had seen the resident crying immediately after the incident and had to comfort the resident. Further interview revealed the CNA had reported the allegation to the nurse at the time of the incident.  Review of the facility's policy Preventing Resident Abuse, revealed "(1) monitoring staff on all shifts to identify inappropriate behavior toward resident"  Interview with the Administrator and Social Services on March 8, 2011, at 2:45 p.m., in the Administrator's office, confirmed had no knowledge of any allegation and verified no verbal allegation had been investigated.  Resident # 11 was admitted to the facility July 25, 2008, with diagnoses including Senile Dementia, Alzheimer's Disease, Congestive Heart Failure, Hypertension, Osteoarthritis, Joint Pain and Bone/Cartilage Disorder.  Medical record review of the Minimum Data Set dated November 10, 2010, revealed the resident had long and short term memory problems, severe cognitive impairment, was non-ambulatory, required extensive assistance with bed mobility, and two person physical assistance with transfers.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
Medical record review of the nurse's note dated	F 226	Interview with CNAs on March 8, 2011, a confirmed had over remarks to the resident revealed CNA #2 has immediately after the the resident. Further had reported the all time of the incident.  Review of the facility Abuse, revealed " to identify inappropress."  Interview with the A Services on March Administrator's officient knowledge of any at allegation had been Resident # 11 was a 2006, with diagnose Alzheimer's Disease Hypertension, Oster Bone/Cartilage Discontinuous Medical record reviet dated November 10 had long and short is severe cognitive impron-ambulatory, receivith bed mobility, ar assistance with transactions.	#2 (certified nursing assistant) at 2:10 p.m., in the hallway, theard PTA had made harsh dent. Continued interview ad seen the resident crying he incident and had to comfort er interview revealed the CNA egation to the nurse at the cy's policy Preventing Resident (i.)monitoring staff on all shifts riate behavior toward resident dministrator and Social 8, 2011, at 2:45 p.m., in the he, confirmed had no degation and verified no verbal investigated.  Admitted to the facility July 25, he including Senile Dementia, he, Congestive Heart Failure, coarthritis, Joint Pain and order.  Bew of the Minimum Data Set 1, 2010, revealed the resident ferm memory problems, pairment, was guired extensive assistance and two person physical sfers.	F 226	1. The Director of Nursing complet thorough investigation of the anklof unknown origin as a possible in of abuse to Resident #11. Addition investigation of this unusual incide the Director of Nursing did not reconclusive cause of the injury.  2. From the investigation, it could readily determined how the ankle occurred. Therefore, an instance abuse was not identified and action were taken under the circumstant deemed to be appropriate.  3. Random resident interviews will completed by the Director of Soci Services or her designee by Marchin an effort to identify other possibly incidents involving abuse. The Disocial Services will conduct insert the facility staff on the facility's poprocedure regarding allegations of and reporting requirements by Marchine facility staff on the facility's poprocedure regarding allegations of and reporting requirements by Marchine facility staff on the facility's poprocedure regarding allegations of and reporting requirements by Marchine facility is poprocedure includes the monthly Performance Improvement (QA) in The Performance Improvement (QA) in The Performance Improvement (QA) in Representative, Admissions Coor Medical Records Representative, representative, representatives from other departing an ecessary.	e injury instance onal ent by veal any not be injury of ons that ees were all be all the state of vices for licy & f abuse irrector of vices for licy & f abuse irrector, , Social rs, enance dinator, and ments,

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE S	
		445491	B. WING		03/0	9/2011
104404000000000000000000000000000000000	NAME OF PROVIDER OR SUPPLIER  MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP COD 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(ÉACH DEFICIENÇY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	COMPLETION DATE
F 226	January 30, 2010, r ankle noted to be voon, also outer aspecolor. Tender to tou (name) notified of I bruising, order rec'd X-ray notified" at Attorney) made away order-to be here to 12:00 p.m. " Spok of Attorney) about p when X-ray arrives. called to Dr (name) ice packs as tol. (to notify DPOA"	evealed at 8:15 a.m. "Left ery swollen-unable to fit shoe of of ankle bruised-blue in ich" at 8:30 a.m. "Dr L (left) ankle swelling & (and) if (received) for X-ray-(name) 8:40 a.m. "POA (Power of are of ankle condition & new see resident this pm" at the with DPOA (Durable Power of t. (patient) Will notify DPOA" at 6:30 p.m. " X-ray report & order rec'd for Ace wrap & lerated)Nurse manager to	F 2:	26		
	dated January 30, 2Fracture:None, ex Continued medical inote dated February revealed "Reside foot, ankle. Dr (nam DPOA notified"  Medical record revier report dated February "Minimally displace the lateral malleolus mineralization: Oste below normal level).  Review of facility reviewed an investigat origin on February 3 ankle injury was distentional expension reviewed and the investigation reviewed and the investical reviewed and the investigation reviewed and the investigation	record review of the nurse's y 3, 2011, at 11:20 a.m. nt c/o (complaint of) pain in L ne) notified and orders rec'd.  ew of the left ankle X-ray ary 3, 2011, revealed ed fracture through the tip of a (ankle bone), Bone eopenic (reduced bone mass				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTE	10 I OK MEDICAKE	A MEDICAID SERVICES			OIND MC	. <del>09</del> 36-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445491	B. WING		03/0	09/2011
560,000,000,000	PROVIDER OR SUPPLIER  DREE VILLAGE INC			REET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 226	Continued From pacare of the resident interviews of staff of that date were conditioned. Interview with Direct 2011, at 9:15 a.m., confirmed the facilition investigation of the c/o27666 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters t	ge 4 con January 30, 2011. No aring for the resident prior to ducted.  Stor of Nursing #2, on March 9, in the conference room by failed to conduct a complete injury of unknown origin.  ENT/SVCS TO RESSURE SORES  The rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having enves necessary treatment and healing, prevent infection and from developing.  It is not met as evidenced ecord review, observation, actifity failed to provide evice for two residents (#5, issess a wound timely for one only-six residents reviewed.	F 226	F 314 Treatment/Svcs to prevent/he sores:  1. A pressure relief mattress was implaced on Resident # 5's bed. Resident reassessed per policy. 2. All residents with pressure ulcers audited to determine assessments a completed per policy. Residents wit interventions of pressure relief mattreassessed by the Director of Nursing designee. 3. The Director of Nursing or her desinservice nursing staff regarding presmattresses by March 29th. A new "Nadmission Assessment" form has be implemented which includes measur the time of admission when patients admitted with wounds. 4. The Director of Nursing, Unit Madesignee will monitor residents with sintegrity interventions - pressure relief mattresses - weekly until compliance achieved. The Director of Nursing wifindings during the monthly Performal Improvement (QA) Committee includ Medical Director, Administrator, Director, Nursing, Social Services Director, Sursing, Sursing, Sursing, Sursing, Sursing, Sursing,	mediately dent #5 has have been re h esses were or her signee will ssure relief vursing een eements et are nagers, or skin ef e is Il report ance rformance les the ctor of urse r.	
	February 10, 2011, Rehabilitation Service	mitted to the facility on with diagnoses including ces, Aftercare for Hip etes, and Hypertension.		Maintenance Representative, Admiss Coordinator, Medical Records Repre and representatives from other depa necessary.  Completion date	sentative	April 7, 2011

#### PRINTED: 03/11/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445491 03/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD MCKENDREE VILLAGE INC HERMITAGE, TN 37076 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 5 F 314 (continued) F 314 Medical record review of the nursing admission 1. Resident #15 was reassessed during assessment dated February 10, 2011, revealed a the survey and an order clarification was wound on the coccyx area. The documentation received for posey boots, which were the revealed no description or assessment of the pressure relieving device of choice and wound. Review of the weekly skin assessment were already in place on both of the record dated February 10, 2011, revealed a patient's heels. check for alteration in skin integrity with no 2. All residents with pressure ulcers have description of the wound on coccvx. Continued been audited to determine assessments review of the next weekly skin assessment are completed per policy. Residents with revealed was February 24, 2011, (14 days). The interventions of pressure relieving devices documentation did not reveal description or any were assessed by the Director of Nursing type of measurement of the wound. Medical or her designee. record review of the Braden Scale (for predicting 3. The Director of Nursing or her pressure sore risk) dated February 10, 2011, designee will inservice nursing staff revealed a score of 14, (score of 12 or less regarding pressure relieving devices by represents high risk), March 29th. A new "Nursing Admission Assessment" form has been implemented Medical record review of the treatment record which includes measurements at the time dated February, 2011, revealed the treatment to of admission when patients are admitted the coccyx was to be cleanse buttocks with with wounds. normal saline, pat dry, cover with 4 x4 allevyn 4. The Director of Nursing, Unit adhesive, change every three days and as Managers, or designee will monitor needed. Continued review of the treatment record residents with skin integrity interventions dated February 2011, revealed the resident's pressure relieving devices - weekly until ... treatment to the coccyx was changed on compliance is achieved. The Director of February 16, 2011, to cleanse buttocks with Nursing will report findings during the normal saline, pat dry, apply nystatin powder monthly Performance Improvement (QA) every shift. meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Medical record review of the nursing daily Nursing, Social Services Director, Nurse summary dated February 17, 2011, revealed Managers, Housekeeping Supervisor, "open areas noted to the coccyx." Continued Maintenance Representative, Admissions review revealed nursing summary notes dated Coordinator, Medical Records February 24, 2011, revealed "buttocks red with

three small open areas." Review of the

documentation revealed no description or

measurement of the open area on the buttocks.

Medical record review of the weekly pressure

Representative, and representatives from

other departments, as necessary.

Completion date

April 7, 2011

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPLE	
		445491	B. WING		03/0	9/2011
	PROVIDER OR SUPPLIER  DREE VILLAGE INC		43	EET ADDRESS, CITY, STATE, ZIP CODI 47 LEBANON ROAD ERMITAGE, TN 37076	E	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	ulcer record dated pressure ulcer was one measure of 3.0 Further review revea pressure relieving.  Observation with the 8, 2011, at 10:35 at revealed two open and the Treament pressure ulcer as a (1) open area 1.1x measurement was Nurse stated pressuranage. Continue	March 3, 2011, revealed the staged at a three and gave 0 x0.9x 0.2 cm (centimeters). Held the intervention was to be	F 314			
	March 9, 2011, at 7 station, confirmed a pressure ulcer with of ulcer on the cocc time of admission, the pressure ulcer not completed until interview with the Ulapse of fourteen diskins assessments the intervention of prot in place.	Init Manager of Two North, on 1:40 a.m., at the nurses' an initial assessment of the description and measurement by was not completed at the land the initial assessment of with the measurements was March 3, 2011. Continued init Manager confirmed the lays between the "weekly". Further interview confirmed bressure relieving device was admitted to the facility on				
	November 15, 2016 Compression Fract	or mitted to the facility of t			8	X - 1-1-1-1

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SI COMPLE	
		445491	B. WING _		03/0	9/2011
NAME OF PROVIDER OR SUPPLIER  MCKENDREE VILLAGE INC			4:	REET ADDRESS, CITY, STATE, ZIP CODE 347 LEBANON ROAD IERMITAGE, TN 37076	6	
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Stage One, and De Medical record revi Request and Respirevealed "Recomboots B/L (bilateral) Medical record revi Plan dated DecemberFloat heels et (a allows"  Medical record revi Order dated March substitute Posey be effective December. Medical record dated revealed the reside wound on the reside wound on the reside wound on the reside wound on the reside wound-shaped wou which measured 1.  Observation on Mathe second floor dinurse's station, rev	ew of a Physician Consultation onse dated December 9, 2010, mendationsapply Multipodus 3-No pressure to B/L heels"  ew of the Weekly Wound Care per 8-29, 2010, revealed and) posey boots, as pt (patient)  ew of a Physician's Telephone 9, 2011, revealed "May pots for Multi-podus boots of 9, 2010"  ew of the Weekly Pressure I March 3 and 9, 2011, and had an unstageable open ent's left heel of the foot.  Wound Treatment Nurse, on 10:00 a.m., in the resident's ident #15 to have a and on the heel of the left foot 3cm (centimeter) by 1.2cm.  Inch 9, 2011, at 7:20 a.m., in hing area, in front of the ealed the resident sitting in a	F 314			
	wheelchair at the d relieving boots on t Observation and In	ining table with no pressure he resident's feet. terview on March 9, 2011, at			ē	
F 323	7:27 a.m., with Lice confirmed the resid relieving boots in p	ensed Practical Nurse (LPN) #1 lent did not have the pressure lace.	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445491	B. Wil	NG_		03/09	9/2011
	ROVIDER OR SUPPLIER  DREE VILLAGE INC			4	REET ADDRESS, CITY, STATE, ZIP CODE 1847 LEBANON ROAD IERMITAGE, TN 37076		45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323 SS=G	The facility must en environment remain as is possible; and adequate supervisi prevent accidents.  This REQUIREMED by: Based on medical review, and intervie supervise and insurfor one resident (#1 reviewed.  The facility's failure in place resulted in #19.  The findings include Resident #19 was a January 12, 2011, v Personal History of Difficulty Walking, a Medical record revidated January 12, 2 m Problem reside resident will not sus (related to) fallInt Medical record revient and record reviewed to fallInt Medical record reviewed february 16, 2011, we february 16, 2011, and medical record reviewed february 16, 2011, and	VISION/DEVICES  Issure that the resident has as free of accident hazards each resident receives on and assistance devices to  NT is not met as evidenced record review, facility policy ew, the facility failed to re safety devices was in place 19) of twenty-six residents  to ensure safety devices were a fall and harm for resident  ed: admitted to the facility on with diagnoses including Fall, Chronic Kidney Disease, and Lack of Coordination.  ew of the resident's Care Plan 2011, revealed, nt is at risk for fallsGoal stain any significant injuries r/t erventionBed/Chair alarm"  ew of a nurse's note dated revealed "resident found in	F	323	F 323 Free of Accident Hazards/ Supervision/ Devices  1. The safety alarm was immedia placed on Resident #19's chair or February 16th following her return the Emergency Room.  2. Other residents with safety alawere immediately assessed to insproper placement of functioning salarms.  3. The nursing department and the department staff will be inserviced Director of Nursing and/or Rehab Department Director or designee March 29th regarding the facility's & procedure for placement of safety alarms.  4. The Director of Nursing, Unit Managers, or designee will monitiplacement of safety alarms three times per week for three (3) week (2) times per week for one (1) week randomly thereafter. The Directon Nursing, Unit Managers, or designee monthly Performance Improvement (QA) The Performance	on from  fro	April 7, 2011
	Medical record revidated January 12, 3 "Problemreside resident will not sus (related to) fallInt Medical record review rebruary 16, 2011,	ew of the resident's Care Plan ; 2011, revealed, nt is at risk for fallsGoal stain any significant injuries r/t erventionBed/Chair alarm"			Housekeeping Supervisor, Mainton Representative, Admissions Cool Medical Records Representative, representatives from other depart as necessary.	enance rdinator, , and	April 7,

10 m J 1 m J

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445491	B. WING		03/0	9/2011	
NAME OF PROVIDER OR SUPPLIER  MCKENDREE VILLAGE INC			43	ET ADDRESS, CITY, STATE, ZIP CODE 47 LEBANON ROAD ERMITAGE, TN 37076		33/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	a hospital emergen 2011, revealed, "foreheadprocedul repair <30 cm (cent Medical record reviewed february 16, 2011, "returned fromER stitches noted to for Review of the facility Protocol Treatment "Based onasset pertinent interventic subsequent falls"  Interview and reviewed the facility of the facility pertinent interventic subsequent falls"	cy report dated February 16, fall lac (laceration) to re performedlaceration timeters)"  ew of a nurse's note dated at 9:00 p.m., revealed (emergency room) 3 (three) rehead"  ity policy for Falls Clinical //Management revealed ssment, the staffwill identify ons to try to prevent	F 323				
							282
				ž.	1 (2 pm (3) (2 pm (4) (2 p		
	L A						